No. 89-1048

IN THE

Supreme Court of the United States

OCTOBER TERM, 1989

FMC CORPORATION,
Petitioner,
v.
CYNTHIA ANN HOLLIDAY,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Third Circuit

AMICI CURIAE BRIEF OF THE TEAMSTERS HEALTH AND WELFARE FUND OF PHILADELPHIA & VICINITY, THE WESTERN PENNSYLVANIA TEAMSTERS AND MOTOR CARRIERS WELFARE FUND, THE DAIRY INDUSTRY-UNION HEALTH AND WELFARE FUND OF PHILADELPHIA & VICINITY, IBEW LOCAL UNION NO. 98 HEALTH AND WELFARE FUND, AND CENTRAL PENNSYLVANIA TEAMSTERS HEALTH AND WELFARE FUND IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

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INTEREST OF THE *AMICI CURIAE*

In *FMC Corporation v. Holliday*, 885 F.2d 79 (3d Cir. 1989), the Third Circuit upheld the validity of a Pennsylvania anti-subrogation statute which had been challenged as preempted by § 514 of the Employee Retirement Income Security Act, 29 U.S.C. § 1144. The court employed a three-pronged analysis, finding that the state statute was: (1) initially preempted by ERISA § 514(a), 29 U.S.C. § 1144(a); (2) withdrawn from preemption by the "savings clause" for state laws which regulate insurance, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A); and (3) not re-subjected to preemption by the "deemer clause" of ERISA § 514(b)(2)(B), 29 U.S.C. § 1144b)(2)(B). The facts of the case and the Third Circuit's analysis are fully set forth in FMC Corporation's petition for writ of *certiorari*.

This brief in support of the petition is submitted on behalf of five multiemployer welfare plans (collectively designated the "Funds") which are based in Pennsylvania and, thus, directly affected by the statute sustained by the Third Circuit.[1] Each Fund is administered by Trustees, appointed in equal numbers by management and labor, who owe their exclusive fiduciary obligations

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[1] The Funds are established pursuant to § 302(c)(5) of the Labor Management Relations Act, 29 U.S.C. § 186(c)(5), ("LMRA") and § 3(1) and (37) of ERISA Act, 29 U.S.C. §§ 1002(1) and (37) ("ERISA").

to that Fund's participants and beneficiaries. *See NLRB v. Amax Coal Co.*, 453 U.S. 322, 332-34 (1981). The Funds are financed by contributions which are paid at rates negotiated by constituent unions and employers. *United Mine Workers of America Health & Retirement Funds v. Robinson*, 455 U.S. 562, 570-76 (1982). Therefore, unlike insurance companies, the Funds have no independent power to increase their incoming contributions.

The Funds have two critical interests in this case. First, each Fund has a subrogation provision which is essentially identical to the clause invalidated in the FMC Corporation plan. These subrogation provisions are designed to preserve finite trust assets by preventing duplicative compensation for one injury, a practice which is colloquially known as "double dipping." If *Holliday* remains intact, the Funds' ability to prevent "double dipping" will be greatly impaired, and less money will be available to provide benefits for participants and beneficiaries who have no source other than the Funds for medical benefits.[2]

Second, and perhaps more ominously, the logic of the Third Circuit's opinion would subject self-funded benefit plans, such as the Funds, to open-ended state interference with cost containment practices. That result would totally flout the policies underlying ERISA and, in today's economy and political climate, would constitute a disaster for the Funds and other similarly-situated benefit plans.

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[2] The impact of this outcome cannot be minimized, regardless of whether the case is viewed from the perspective of the Funds or on a national basis. The Pennsylvania statute sustained by the Third Circuit guarantees duplicative compensation for injuries arising from automobile accidents in which tort recoveries are secured. As shall be explained at note 13 *infra*, and accompanying text, tens of billions of dollars are spent each year in the United States for medical care and disability arising from automobile accidents. Obviously, the potential for "double dipping" is enormous.

A. THE THIRD CIRCUIT'S DECISION WOULD DIVEST THE FUNDS OF AN IMPORTANT COST CONTAINMENT MEASURE.

The exploding cost of medical care is causing a national crisis. Self-insured benefit plans must respond with effective measures to contain costs. The Funds' subrogation policies are precisely the type of cost containment provision mandated by the present crisis. The Third Circuit's challenge to subrogation hampers the cost containment effort and, thus, threatens the Funds, their participants, and their beneficiaries.

1. *The National Health Care Crisis.*

In 1988, the Congressional Research Service of the Library of Congress conducted a study on health care in the United States at the request of the House of Representatives' Committee on Education and Labor and the Senate's Special Committee on Aging. According to the final report:

> . . . During the 1980's premium rates [for health insurance] increased rapidly, but the increase slowed between 1984 and 1987. However, *increases for 1988 and 1989 are expected to resume the high growth rate of the early 1980's.*
>
> In 1977, the average monthly premium for enrollee coverage was $25 and the average for family coverage was $65. Taking into account medical care inflation as indicated by the medical care portion of the CPI, these premiums would have been equal to $57 for individuals and $148 for family. In 1987, the average enrollee premiums had risen by 35 percent in real terms to $77 and family premiums had risen to $201.

Congressional Research Service, Library of Congress, *Health Insurance and the Uninsured: Background Data and Analysis*, pp. 65-66 (1988) (emphasis added).

The prediction of renewed inflation after 1987 came true with a vengeance. According to the United States Chamber of Commerce, the cost of providing medical cov-

erage to employees rose by 19% in 1988. Geisel, *Health Benefit Tab Rises 19% to New High*, Business Insurance, December 11, 1989 at 1. In 1989, costs for multiemployer funds skyrocketed on a national basis by between 20% and 40%.[3] According to the AFL-CIO, in the future "health care costs will continue to rise anywhere from 18 to 31 percent per year." DeWolf, *Health Care Benefits A Continuing Issue*, Philadelphia Daily News, January 12, 1990 at 81, 82.

The extent of the crisis is graphically demonstrated by the degree to which it has generated labor-management turmoil. The cost of health care was the most divisive issue of the nine-month strike in Appalachia which the United Mineworkers conducted against Pittston Coal Company. Indeed, on the day of the settlement, Labor Secretary Elizabeth Dole announced that a special federal commission would be appointed to study the problem of health care costs. Kilborn, *Dole Winning Applause for Labor Department Actions*, New York Times, January 4, 1990 at 16, col. 1.[4]

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[3] During the first half of 1989, inflation for multiemployer plans averaged "20-22% annually for medical care and about 13% for dental care." Johnson, *Flexible Benefits for Multiemployer Plans*, Employee Benefits Journal, June 1989 at 31. Later that year, costs rose "an average of 20-40%." Grossi, Yu, Astor & McCarthy, *The Pre-Estimate Program: An Effective Way to Reduce Surgical Fees While Preserving High Quality Care and Patient Choice*, Employer Benefits Journal, December 1989 at 2. *See also*, Geisel, *Repeal of Section 89 Most Important Event for Benefit Managers*, Business Insurance, December 25, 1989 at 3 ("In 1989, health care costs for indemnity plans increased 20% to 50%, while health maintenance organizations boosted premiums about 17% on overage, several surveys found"); Gaul, *Area Hospitals Undergo A Shakeout*, Philadelphia Inquirer, January 16, 1990 at 1-A, 9-A, col. 3 ("Nationally health care expenditures rose from $248 billion in 1980 to a projected $647 billion in 1990—a 160 percent increase in a decade").

[4] Health care costs sparked many other disputes in 1989, including strikes by 60,000 employees of Nynex Corporation; 140,000 employees of regional Bell Telephone Companies; 2,100 Borg-Warner employees in Indiana, and 1,000 workers at Post Cereal Company's facility in Battle Creek, Michigan. Verespej, *Rx For Costs Elusive*, Industry Week, December 4, 1989 at 88.

The causes of this rampant inflation in medical costs have not been conclusively identified. Different authorities cite factors including: (1) modern technology (which is expensive and prolongs treatment by causing patients to live longer),[5] (2) the effect of mandated benefits laws,[6] (3) increased substance abuse in the workforce,[7] and (4) the onset of AIDS.[8]

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[5] Handel, *The Renewed Surge in Health Care Inflation*, Employee Benefits Digest, December 1988 at 7-8; Katz, *Fear and Trembling on Benefits Trail*, National Underwriter Property & Casualty/Employee Benefits Edition, December 5, 1988 at 9; Adler, *Radical Changes in Benefits Loom*, Business Insurance, November 7, 1988 at 14.

[6] By mid-1989, 34 states had adopted laws requiring insurers to provide certain types of benefits (*e.g.*, chiropractic services) in order to do business in those states. Such laws tend to increase the price of health care throughout the entire jurisdiction, because they encourage providers to raise their fees to meet the mandated benefit levels and consumers to increase usage. Haistmaier, *Why America's Health Care System Is In Crisis*, Heritage Foundation Report, May 30, 1989 at 1.

[7] One author has noted the following:

> A dramatic rise in mental health care costs and utilization has been experienced in recent years by employers in terms of out-of-pocket payments for care and of lost productivity due to drug and alcohol abuse and other mental health problems in the work-force. Between 1985 and 1987, psychiatric and substance abuse costs to employers increased 45 percent nationwide. The costs are now rising at about twice the general rate of medical inflation.

Hastings, *Legal Developments in Managed Mental Health Care*, Physician Executive, November-December 1989 at 36. *See also* Diesenhouse, *Drug Treatment Is Scarcer Than Ever For Women*, New York Times, January 7, 1990 at 26 ("[I]t has been estimated that while there are approximately 17.7 million adults with severe alcohol problems and 9.5 million drug users, only 615,000 people are in treatment, with at least 70,000 on waiting lists"); Adler, *Employers Shift Focus to Controlling Costs of Mental Health Care*, Business Insurance, February 20, 1989 at 17 ("Some 20% to 25% of all employer health care expenditures go toward psychiatric and substance abuse treatment . . .").

[8] According to a study conducted by the Alexander & Alexander Consulting Group in early 1988, when the recent health care inflation was just beginning, "[t]he average per-case cost for

Though the causes may be disputed, there is no doubt that drastic action is necessary. The Federal Government has completely revamped its billing procedures in order to cut Medicare and Medicaid costs.[9] Several prominent industrialists, including Chrysler Corporation Chairman Lee Iacocca, have suggested that the only effective remedy may be socialized medicine. Nelson-Hurchler, *U.S. Catching Socialism?*, Industry Week, August 21, 1989 at 45.

2. *The Need for Effective Cost Containment Policies.*

As previously indicated, multiemployer benefit plans have no power to raise their contribution levels to meet the current waive of health care inflation. These levels, determined through the collective bargaining process, are fixed for the duration of the governing labor agreements and are limited by what the contending negotiators are willing or able to pay.[10] Therefore, multiemployer plans

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treatment of AIDS was $103,350." Kittrell, *Large Employers Report More AIDS Cases: Survey*, Business Insurance, February 8, 1988 at 3. These costs will increase as AIDS patients live longer (and thus require more treatment) due to increasingly effective therapies, such as administration of AZT. Chase, *People With AIDS Live Longer Now, Studies Confirm*, Wall Street Journal, January 19, 1990 at B2, col. 7. Pennsylvania, the state directly affected by the *Holliday* opinion, ranks seventh in the nation in the number of reported AIDS cases. Report of the Pennsylvania Bar Association Risk Force on Acquired Immune Deficiency Syndrome at 15 (November 11, 1989).

[9] Title VI of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, sets forth new amendments designed to cut costs for Medicare and Medicaid. Title VI contains over 100 sections which govern numerous matters, *e.g.*, physician fee schedules, durable equipment, mental health services, nursing services.

[10] Many multiemployer plans are in industries which are either financially depressed or increasingly non-union. Since employers which contribute to such plans are often financially stressed, they have difficulty in making adequate benefit contributions. Katz, *Meltdown Forces New Look At Benefit Plan Structure*, Life & Health/Financial Services Edition, January 4, 1988 at 14. The current industrial strife caused by health care inflation further demonstrates

have only two alternatives for dealing with the present inflation in health care, *viz.*, to cut costs and to reduce benefits.

Experts unanimously agree that, to cut costs, ERISA plans must maximize the buying power of their assets. Cynthia K. Hosay, Ph.D., vice president of health services and health care with Martin E. Segal Co., the nationally recognized consulting firm, explains that "[d]uplication in care is costly." Hosay, *Negotiating with Health Care Providers*, Employees Benefits Journal, March 1989 at 3. To contain costs, benefit plans must limit needless and duplicative expenditures by adopting programs such as: (1) a centralized record system to avoid repetitive diagnostic testing, (2) second opinion and utilization review programs, to prevent needless treatment, (3) increased resort to less costly treatment options, *e.g.*, outpatient care, (4) education of participants to help them avoid sickness, and (5) direct negotiations with health providers, such as hospitals, druggists, and physicians, in order to cut prices through volume discounts, preferred provider organization arrangements, and *per diem* contracts. Dr. Hosay's opinion is in accord with both the consensus of experts,[11] and the policies underlying ERISA. The Congressional Findings and Statement of Policy which begin the statute specifically state that securing the "financial soundness" of benefit plans is a primary purpose of the legislation. ERISA § 2(a), 29 U.S.C. § 1001(a).

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the uncertainty inherent in relying upon the collective bargaining process. *See supra* note 4, and accompanying text.

[11] *E.g.*, Sizemore, *Concerns on Cost Lead to Innovation*, Pension & Benefits, Fall 1989 at 13; Haggerty, *Direct Health Contracting Curbs Costs: Consultant*, National Underwriter Property & Casualty/Employee Benefits Edition, May 22, 1989 at 21; Cave, *Direct Contracting With Hospitals: Alternative Payment Arrangements*, Employee Benefits Journal, June 1989 at 26; *Ozzie and Harriet Package of Employee Benefits Funds*, Chicago Tribune, January 1, 1989 at 37; Gannes, *Strong Medicine for Health Bills*, Fortune, April 13, 1987 at 70.

3. *The Threat to Cost Containment.*

The Funds' subrogation provisions which would be effectively invalidated by the Third Circuit's decision in *Holliday* are simply another type of cost containment measure. The goal is to conserve trust assets by preventing (or recouping) expenditures which are not necessary to provide benefits, because the plan participant or beneficiary has secured compensation from a tortfeasor. Stated simply, subrogation attacks "double dipping."

The concept is hardly radical. The Funds' subrogation policy is highly analogous to 'coordination of benefits," a practice which prevents duplicative compensation by prorating benefit payments between or among different insurers or benefit plans. The right to coordinate benefits is well-recognized in the context of insurance law. 8A Appleman, Insurance Law and Practice §§ 4906-010, at 341-492 (1981); 16 Couch on Insurance 2d (Rev ed) §§ 62.41-62.188, at 475-657 (1983). Coordination should be even more appropriate for self-insured ERISA plans, where the savings translate into benefits for other employees, as opposed to increased profits for insurance companies.[12] The only difference between coordination of benefits and the Funds' subrogation rules is that the latter reduces expenditures in accordance with the amount paid by tortfeasors, rather than other benefit plans. The end result is the same, *i.e.*, more assets for other participants and beneficiaries.

If the Third Circuit's position in *Holliday* remains intact, the Funds will be compelled to pay out hundreds of

[12] Ironically, the Third Circuit is the only court which has considered the extent to which coordination of benefits is applicable to ERISA. In *Northwest Department ILGWU Health and Welfare Fund v. Teamsters Local Union No. 229*, 764 F.2d 147 (3d Cir. 1985), the court indicated that coordination of benefits provisions are valid as long as they do not cause a participant to receive less than he or she would receive in the absence of alternate coverage. *Id.* at 161-62 & n.13. The Funds' subrogation provisions, which only seek to prevent or recoup payments actually received from another source, would clearly pass muster under this test.

thousands, perhaps millions, of dollars to "double dipping" participants and beneficiaries whose claims stem from automobile accidents.[13] These duplicative payments could only be provided in one manner—reducing the trust assets available to provide benefits for participants and beneficiaries who cannot "double dip." To put it bluntly, every dollar lost through "double dipping" will translate into one less dollar available for hospital patients, pregnant mothers, AIDS patients, the long term disabled, and other persons who have no other source of care. To prevent this ridiculous result, which makes a mockery of ERISA's goal to provide employees with quality medical care, this Court should grant the petition for writ of *certiorari*.[14]

[13] The exact amount which subrogation saves benefit plans varies with time, depending upon the number of accidents, the size of the recoveries, and the solvency of the tortfeasors. *Holliday*, for example, is a case where the tortfeasor had limited insurance coverage and an obligation to pay multiple plaintiffs. Nevertheless, the plan could have saved approximately $50,000 through subrogation. Thus, only a handful of accidents of this type can involve hundreds of thousands of dollars.

The widespread litigation which this issue has generated graphically demonstrates that ERISA plans view subrogation as an effective cost containment measure. This is not surprising in light of the staggering cost of automobile related injuries, which are only one type of injury governed by subrogation.

In 1985, the lifetime cost of medical and disability benefits arising from motor vehicle injuries in the United States amounted to $48,683,000,000. Rice & MacKenzie, *Cost of Injury in the United States: A Report to Congress* at 44 (1989). Figures are not available for subsequent years. Estimating an annual rate of increase at 10%, the figures would be: $53,551,300,000 in 1986; $58,906,430,000 in 1987; $64,797,073,000 in 1988; and $71,276,780,000 in 1989. These figures are conservative in light of roaring rates of inflation currently experienced in health care.

[14] The Third Circuit's decision is anomalous in another respect. Fiduciaries of a trust fund have a common law duty to treat all beneficiaries impartially. Restatement (Second) of Trusts § 183. Under ERISA, this principle has been expanded to require even handed treatment designed to secure "the greatest good for the greatest number." Silverman, *Legal and Ethical Responsibilities*

B. THE THIRD CIRCUIT'S DECISION THREATENS TO SUBJECT THE FUNDS, AND OTHER SELF-INSURED BENEFIT PLANS, TO UNFETTERED STATE INTERFERENCE WITH COST CONTAINMENT POLICIES.

The *Holliday* opinion's challenge to sound cost containment policy is by no means limited to the specific mechanism of subrogation. According to the Third Circuit, state insurance laws are only preempted to the extent that they involve "core" ERISA concerns, such as rules governing "reporting, disclosure, and non-forfeitability" of rights. *FMC Corp. v. Holliday*, 885 F.2d at 88. While the Third Circuit's definition of "core" concerns is murky, the very holding of *Holliday* excludes cost containment measures, such as subrogation, from "core" concerns. This relaxed definition of ERISA preemption is very significant, because many cost containment measures are presently under siege in state courts and legislatures.

The reason for this siege is simple, *viz.* cost containment causes "a loss of revenue to health care providers." Handel, *supra* at 7. Health care providers, in turn, have counterattacked, often resorting to state law.

Pennsylvania, for example, is experiencing an assault upon the ability of benefit plans to negotiate exclusive dealing arrangements with certain pharmacists in exchange for volume discounts. As previously explained, arrangements of this nature are strongly recommended

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of Health and Welfare Fund Trustees, Employee Benefits Digest, February 1989 at 3, 5. *See District 2, UMW v. Helen Mining Co.*, 762 F.2d 1155, 1160-61 (3d Cir. 1985), *cert. denied*, 474 U.S. 1006 (1985).

The Pennsylvania statute in this case discriminates in favor of persons injured in automobile accidents, by granting them a special exemption from subrogation, while victims of other accidents can be denied duplicative recoveries. This disparate treatment is totally inconsistent with ERISA.

by experts in the health field as an effective means for maximizing an ERISA plan's purchasing power. *See supra* note 11, and accompanying text. Fearing that these arrangements will succeed in cutting the cost of prescriptions, a lobbying group for druggists named the Pennsylvania Pharmaceutical Association has proposed legislation to prevent insurance companies and ERISA plans from negotiating such contracts. This legislation has broad support. Benson, *Pharmacy Bill Would Target Private Pacts*, Pittsburgh Business Times & Journal, June 19, 1989 at 15. If the legislation passes and is challenged on the basis of ERISA preemption, the legislation's proponents would certainly cite *Holliday* for the proposition that cost containment measures are not preempted. Success on such an argument would rob the Funds of another important method to contain costs (and, thus, to maximize benefits).

Similarly, in *Varol v. Blue Cross & Blue Shield*, 708 F. Supp. 826 (E.D. Mich. 1989), a group of physicians argued that Michigan law prohibited a variety of widely-recognized procedures crafted to prevent unneeded or duplicative medical procedures, *e.g.*, preauthorization and concurrent utilization reviews. The court ruled against the physicians on the ground that ERISA preempted the state law in question. The Third Circuit's analysis, however, could lead to a contrary result with regard to any state laws inconsistent with such cost containment policies. In that event, the physicians' lobby would be an additional threat to the Funds and other self-funded benefit plans.

Yet lawyers probably pose the most potent threat to cost containment. The hostility of the plaintiff's bar to certain forms of cost containment is demonstrated by the *amicus curiae* brief which the Pennsylvania Trial Lawyer's Association ("PTLA") filed in *Holliday*. 885 F.2d at 85. Trial lawyers, moreover, are a powerful force on the state law level. In Pennsylvania, for example, they

have played a major role in shaping automobile insurance laws, the source of the "double dipping" provision which gave rise to this litigation. Cohn, Fish & Enda, *How Interest Groups Mold Pa.'s Auto Insurance System*, Philadelphia Inquirer, October 23, 1989 at 1-A, col. 1 ("[T]oday, as in 1983 [when the current automobile legislation was enacted], a large part of the decision-making process has fallen under the influence of . . . the trial lawyers who profit tremendously from the state's insurance system"); Statement of State Representative Andrew J. Carn, PR Newswire, January 10, 1990 (available on NEXIS) (identifying the Pennsylvania Trial Lawyers Association as one of the organizations which "wrote the present laws governing auto insurance in . . . Pennsylvania").

During the legislative debate on ERISA, Senator Williams delivered the report of the Conference Committee to the full Senate. His remarks at that time included a discussion of ERISA preemption. He observed that "[s]tate professional organizations acting under the guise of state-enforced professional regulation, should not be able to prevent unions and employers from maintaining the types of employee benefit programs which Congress has authorized." 120 Cong. Rec. 23,933 (1974). As a floor manager of ERISA, Senator Williams' comments merit considerable weight. Indeed, the Third Circuit's opinion recognized the Senator's statement as an accurate expression of the Congressional intent underlying ERISA. 885 F.2d at 87. This recognition is ironic since the logic of *Holliday* would place self-funded ERISA plans at the mercy of state laws enacted or invoked by "state professional organizations."

SUMMARY OF ARGUMENT

This Court should grant the writ of *certiorari* for two reasons, apart from those already set forth in the pending petition. *First*, in 1982 Congress amended ERISA to exempt the Hawaii Prepaid Health Insurance Act from the preemptive scope of § 514. The language and legislative history of that provision prove that the "deemer clause" of ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), was intended to exempt self-insured plans from regulation by the other forty-nine states. *Second*, cost containment measures such as subrogation do not constitute the business of "insurance" under the "savings clause" of ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). Hence, the Pennsylvania statute should be preempted regardless of the interpretation given to the "deemer clause."

REASONS WHY THE WRIT SHOULD BE GRANTED

The petition for writ of *certiorari* sets forth several important reasons for granting the writ, particularly: (1) the need to resolve the split in the Circuits, and (2) the flat inconsistency between *Holliday* and this Court's decision in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 746 (1985). Indeed, the clash with *Metropolitan Life* is so serious that the Third Circuit's decision is a candidate for summary reversal, *e.g.*, *Stone v. Graham*, 449 U.S. 39 (1980).

The Funds endorse the arguments contained in the petition and will not repeat them. There are, however, additional reasons for granting the writ.

I. THE THIRD CIRCUIT'S INTERPRETATION OF ERISA PREEMPTION IS DISCREDITED BY THE AMENDMENT OF ERISA CONTAINED IN THE PERIODIC PAYMENT SETTLEMENT ACT OF 1982.

The Third Circuit's decision in this case springs from a fundamental misreading of the "deemer" clause in ERISA § 514(b)(2)(B), 29 U.S.C. § 1114(b)(2)(B).

As this Court correctly observed in *Metropolitan Life*, 471 U.S. at 747, that clause insulates self-insured plans from state regulation. In *Holliday*, conversely, the Third Circuit concluded that the clause only protects "core ERISA concerns," a term which the court never clearly defined. 885 F.2d at 88. This analysis is inherently flawed as nothing in the language or legislative history of ERISA limits the deemer clause to "core" matters.

Any lingering doubt over the issue is dispelled by an amendment to ERISA contained in the Periodic Payment Settlement Act of 1982 "(PPSA)", codified in § 514(b)(5) of ERISA, 29 U.S.C. § 1144(b)(5), which provides that the preemption provisions of ERISA "shall not apply to the Hawaii Prepaid Health Care Act (Haw. Rev. Stat. §§ 393-1 through 393-51)." The establishment of this specific exception for Hawaii illustrates the full breadth of preemption which governs other states.

The PPSA must be read in light of two significant cases which preceded it. In *Hewlett-Packard Co. v. Barnes*, 571 F.2d 502 (9th Cir. 1978), *cert. denied*, 439 U.S. 831 (1978), the Ninth Circuit held that a California statute was preempted to the extent that it affected a self-insured employee benefit plan. The court explained that "[a]lthough Section 514(b)(2)(A) exempts from preemption state regulation of insurance, Section 514(b)(2)(B) provides that *employee benefit plans may not be considered to be in the business of insurance for purposes of the exception to preemption.*" 571 F.2d at 504 (emphasis added). In short, the Ninth Circuit adopted an interpretation of the deemer clause which flatly exempts self-funded plans from state law and, thus, contradicts the position which the Third Circuit would later take in *Holliday*.

One year after *Hewlett-Packard*, the Ninth Circuit considered the affect of ERISA preemption upon the Hawaii Prepaid Health Care Act, which required employers doing business in Hawaii to furnish employees with certain mandated benefits. Standard Oil of California, which maintained a self-funded plan for its employees in that state, brought a declaratory judgment action, arguing that the Hawaiian legislation was preempted by ERISA. Citing *Hewlett-Packard*, the Ninth Circuit agreed that the state statute was preempted. *Standard Oil of California v. Agsalud*, 633 F.2d 760, 766 (9th Cir. 1979), *aff'd mem.*, 454 U.S. 801 (1981). Hawaii then sought relief in Congress.

On October 1, 1982, Senator Robert Dole of Kansas reported the PPSA to the Senate on behalf of the Finance Committee. He noted that the bill "includes four provisions, each of merit and I believe noncontroversial." Senator Dole then introduced Senator Spark Matsunaga of Hawaii who discussed one of these provisions, *i.e.*, "a committee amendment which rescues the Hawaii Health Care Act from preemption by the Employee Retirement Income Security Act of 1974." 128 Cong. Rec. 26,902 (1982). Senator Matsunaga discussed the *Standard Oil of California* litigation, describing the ultimate judicial determination that "the broad language of ERISA preempted all state law relating to private employee benefit plans including Hawaii's Prepaid Health Insurance Act." 128 Cong. Rec. 26,903 (1982). He noted that, in 1979, Congress failed to pass a bill designed "to exempt from preemption state health insurance law" throughout the nation, and that opponents of the *Standard Oil of California* decision had then limited their efforts to exempting "only the Hawaii statute." With no further debate on the issue, the Senate passed the bill unanimously.

On December 13, 1982, Congressman Rostenkowski introduced the PPSA to the House of Representatives. He noted that the House Committee on Education and Labor had amended the Senate's Hawaiian exemption by including language "to the effect that the exception made by this legislation is not to be considered a precedent for extending the exception to other state laws." 128 Cong.

Rec. 30,352 (1982). Congressman Erlenborn then made the only significant speech on the Hawaiian proviso, in which he gave the following explanation of the legislation:

> Last year the Supreme Court let stand the decision of the Ninth Circuit Court of Appeals in Standard Oil of California against Agsalud that the broad preemptive framework relating to pension and welfare (for example, health) plans agreed to by the ERISA conferees does in fact supersede the Hawaii statute. The agreement to amend ERISA to permit the future application of the Hawaii law was reached solely on the basis and with the understanding that *the Hawaii law is an unusual special case*, inasmuch as the law was enacted just prior to the signing of ERISA on September 2, 1974, and that the law will be permitted to operate only as a narrow exception which is not expected to do violence to the strong Federal preemption scheme. *In agreeing to the Hawaii exception this body will be reaffirming the broad scope of ERISA preemption and the validity of the interpretation of the Federal courts in connection with the Hawaii statute.* To help allay the fears of those who might otherwise view this action as the beginning of a weakening of Federal preemption under ERISA, *the amendment contains an explicit statement that this limited exception shall not be considered a precedent with respect to extending similar treatment to any other State law.*

128 Cong. Rec. 30,356 (1982) (emphasis added).

The bill was then referred to the Conference Committee to reconcile the difference caused by the House amendment, which emphasized that the Hawaii exception would not serve as a precedent for other states. The Committee recommended the House version, which was then enacted into law.[15] 128 Cong. Rec. 33,183; 33,236; 33,240; 33,263; 33,433 (1982).

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[15] The full text of the House amendment to the Hawaiian exception stated, "The amendment made by this section shall not be considered a precedent with respect to extending such amendment to any other State law." The amendment was eventually codified at § 301 of Pub. L. No. 97-473 and the notes to 29 U.S.C. § 1144.

The language and history of the PPSA totally undermine the Third Circuit's position in *Holliday*. In 1982, Congress adopted the Ninth Circuit's broad interpretation of the deemer clause, which insulates self-insured benefit plans from the laws of every state, except Hawaii. Pennsylvania and the other states of the Union remain governed by the interpretation of ERISA set forth in the Ninth Circuit's *Hewlett-Packard* and *Standard Oil of California* decisions. These Ninth Circuit opinions anticipated the language concerning self-insured plans in *Metropolitan Life*, 471 U.S. at 747, which the Third Circuit cavalierly dismissed as "dicta." The PPSA demonstrates that the Third Circuit's interpretation of the deemer clause was simply wrong.

II. THE DECISIONS OF THIS COURT DEMONSTRATE THAT THE PENNSYLVANIA ANTI-SUBROGATION STATUTE DOES NOT FALL WITHIN THE "SAVINGS" CLAUSE FOR STATE INSURANCE LAW.

An integral part of the Third Circuit's ruling in *Holliday* was its preliminary determination that Pennsylvania's statutory ban on subrogation "regulates insurance" within the meaning of ERISA's "savings clause." *Holliday*, 885 F.2d at 85-86. This conclusion directly contradicts the subsequent holding of *Baxter v. Lynn*, 886 F.2d 182 (8th Cir. 1989), which found the "savings clause" inapplicable to state anti-subrogation laws. Drawing upon the "analysis under the McCarran-Ferguson Act," the Eighth Circuit distinguished subrogation from the "business of insurance," noting that:

> The practice of subrogation does not transfer the risk from a policyholder to his or her insurer.

> Rather, it limits the recovery available to the policyholder by preventing a double recovery.

886 F.2d at 186.

Thus, *Baxter* and *Holliday* present the additional issue of whether a cost containment device which prevents "a double recovery" of employee benefits is subject to state law. Review of that issue by this Court would not only resolve a conflict among the Circuits,[16] but would also significantly expand the importance of this case. If state laws which govern subrogation and other cost containment innovations do not fall within the savings clause, then they are preempted with respect to *all* ERISA plans, both insured and non-insured. Consequently, a conclusive interpretation of the savings clause would be significant for virtually every ERISA plan in the nation.

The McCarran-Ferguson Act, 15 U.S.C. §§ 1101-015 *et seq.*, provides an exemption from the antitrust laws for the "business of insurance." The definition given to "business of insurance" in the McCarran-Ferguson Act is a major criterion for determining the meaning of "insurance" under the savings clause of ERISA. *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 48-49 (1987). This Court's cases concerning the McCarran-

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[16] Actually, the cases which concern the relationship of the savings and deemer clauses with respect to subrogation are chaotic. In *Holliday*, the Third Circuit held that state laws in this area survive preemption under both clauses while, in *Baxter*, the Eighth Circuit held that these laws fail under both clauses. A third view holds that state anti-subrogation laws survive preemption under the savings clause but, with respect to self-insured funds, fail under the deemer clause. *E.g., United Food & Commercial Workers & Employers Arizona Health & Welfare Trust Fund v. Pagyca*, 801 F.2d 1157, 1160-62 (5th Cir. 1986).

Hence, depending upon the Circuit, state laws regulating subrogation may be: (1) preempted for all ERISA plans, (2) enforceable with respect to all plans, or (3) preempted for self-insured ERISA plans and binding upon insured plans.

Ferguson exemption demonstrate that subrogation laws cannot be equated with "insurance" laws.

In *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), a group of pharmacists sued an insurance company, Blue Shield, under the antitrust laws. Blue Shield had negotiated agreements with pharmacists throughout Texas. These agreements required participating pharmacists to give Blue Shield a substantial discount. The plaintiffs alleged that the practice amounted to price-fixing and a group boycott. Blue Shield countered that the discount practice was part of the "business of insurance" and, thus, exempt under McCarran-Ferguson. This Court disagreed with Blue Shield, noting that "[t]he primary elements of an insurance contract are the spreading and underwriting of a policyholder's risk." According to *Royal Drug*:

> The Pharmacy Agreements . . . do not involve any underwriting or spreading of risk, but are merely arrangements for the purchase of goods and services by Blue Shield. By agreeing with pharmacies on the maximum prices it will pay for drugs, *Blue Shield effectively reduces the total amount it must pay to its policyholders.* The Agreements thus enable Blue Cross *to minimize costs and maximize profits. Such cost-savings arrangements may well be sound business practice, and may well inure ultimately to the benefit of policyholders in the form of lower premiums, but they are not the "business of insurance."*

440 U.S. at 214 (emphasis added).

Royal Drug was reaffirmed in *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119 (1982), where an insurance company employed a utilization review committee of chiropractors to determine whether chiropractic bills submitted by insureds were excessive. When the plaintiff, a chiropractor, challenged the practice under the antitrust laws, the respondent invoked the McCarran-Ferguson exemption for "the business of insurance."

Citing *Royal Drug*, this Court found the exemption inapplicable.

Royal Drug and *Pireno* stand for the proposition that "cost-savings arrangements" designed to minimize the expenditure necessary to provide certain benefits are not the "business of insurance." Hence, while cost containment measures may be challenged under the federal antitrust laws (if any such challenge has merit), ERISA insulates them from attack under state law. The Third Circuit would give cost containment the worst of all worlds, denying favorable treatment under either McCarran-Ferguson or ERISA. That result would controvert the will of Congress, flout the precedents of this Court, and, in view of the importance of sound cost containment to the health care system, disserve the interests of all American workers and their families.

CONCLUSION

For the foregoing reasons, FMC Corporation's petition for a writ of *certiorari* should be granted.

Respectfully submitted,

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